ChiLDReNLink

Form 25H Coagulopathy			
B: COAGULOPATHY			
B1a	Visit Date:	___ ___ / ___ ___ / ___ ___ ___ ___	
B1a	Date of presentation/onset:	___ ___ / ___ ___ / ___ ___ ___ ___	
B2	Ongoing?	O No	O Yes → **go to B4**
B3	If No, indicate date of resolution:	___ ___ / ___ ___ / ___ ___ ___ ___	
B4	Was patient hospitalized?	O No → **go to B8**	O Yes
B5	If Yes, date of admission:	___ ___ / ___ ___ / ___ ___ ___ ___	
B6	Was patient discharged?	O No → **go to B8**	O Yes
B7	If Yes, date of discharge:	___ ___ / ___ ___ / ___ ___ ___ ___	
B8	Easy bruising?	O No	O Yes
B9	Epistaxis?	O No	O Yes
B10	Hematochezia?	O No	O Yes
B11	Other source of bleeding?	O No	O Yes
B12	Date of labs:	___ ___ / ___ ___ / ___ ___ ___ ___	
B13	Prothrombin time (maximal value):	O = O < O > ___ ___ ___	O sec O Not Done
B14	Partial thromboplastin time (PTT):	O = O < O > ___ ___ ___	O sec O Not Done
B15	Platelet count:	O = O < O > ___ ___ ___	O x10^3/mm^3 O x10^9/L O Not Done
B16	INR (maximal value):	O = O < O > ___ ___ ___	O Not Done
B17	Response to Vitamin K:	O No	O Yes O Not Done
B18	Confirmed by medical record:	O No	O Yes